

05568

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Church</u> 83X 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McCreedy Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Fletcher</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1937</u>	9. AGE (In years last birthday) <u>20</u> yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>saw-mill</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gordon Fletcher</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Drummond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>228-44-7810</u>		17. INFORMANT Address <u>Hattie Fletcher Withams, VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>825X Intracerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>automobile accident</u>					
20c. TIME OF INJURY Hour <u>3 a. m.</u> Month <u>May</u> Day <u>19</u> Year <u>1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State Road</u>		20f. (City or town) <u>Kingston</u> (County) <u>BFD</u> (State) <u>Somerset Md</u>			
21. I certify that I attended the deceased from <u>May 19, 1957</u> to <u>May 19, 1957</u> , that I last saw the deceased alive on <u>May 19, 1957</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah M. Peyton</u>				DATE SIGNED <u>May 21</u>			
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>				<u>Crisfield, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-21-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Withams</u>		22d. LOCATION (City, town, or county) (State) <u>Withams, VA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> ADDRESS <u>New Church, VA.</u>				24a. REC'D BY REGISTRAR <u>5/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>Barbara Adams</u>	

W

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

## CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		AGE [Faint text]	
SEX [Faint text]		RACE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

BUREAU V. S.

MAY 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05569

CERTIFICATE OF DEATH

05559

Reg. Dist. No. 268

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deal Island</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deal Island</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CIT Home</b>				d. STREET ADDRESS — —			
3. NAME OF DECEASED (Type or print) First <b>Yvonne</b> Middle <b>Handy</b> Last <b>Wallace</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>col</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 23 - 1936</b>	
9. AGE (In years last birthday) <b>20</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>ALONZA WALLACE</b>				14. MOTHER'S MAIDEN NAME <b>ALICE JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-32-8538</b>		17. INFORMANT <b>ALICE WALLACE</b> Address <b>Mother Deal Island, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Glomerular nephritis</b> <b>593X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Holampsie during last pregnancy</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-29-57</b> , 19____, to <b>5-1-57</b> , 19____, that I last saw the deceased alive on <b>5-1-57</b> , 19____, and that death occurred at <b>10:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>5/4/57</b> ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D. PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b> <b>Dames Quarter, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>5/5/57</b>		22c. NAME OF CEMETERY OR INTERMENT <b>John Wesley</b>		22d. LOCATION (City, town, or county) (State) <b>Deal Island Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. S. Sutter</b>				24a. REC'D BY REGISTRAR <b>3/6/57</b>		24b. REGISTRAR'S SIGNATURE <b>Lola S. Whalley</b>	

# CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. No. 10

70

1

May

XXXXXX

Female

White

Female

6-01

X

Residence

Residence

Place of Birth

Place of Birth

Place of Death

Place of Death

BUREAU Y H

MAY 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G217 6-20-57 et

CERTIFICATE OF DEATH

05560

Reg. Dist. No. 265

05565

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>38 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Crisfield</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>134 N. Somerset Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>FLORENCE</b> Last <b>HODGE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1872</b> <b>May 30, 1862</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Shippensburg, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Levi Allen Lyne</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Eleanor Bingham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Elizabeth Hodge-134 N. Somerset Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anterior chestic Heart Disease</b> (c) <b>Arteriosclerosis -</b> <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>3 years</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> , to <b>May 24, 1957</b> that I last saw the deceased alive on <b>May 24, 1957</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>May 25, 1957</b>			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.		DATE SIGNED <b>May 25, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Sarah M. Peyton</b>		Main St.—Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 27, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Northeast Methodist Ceme.</b>		22d. LOCATION (City, town, or county) (State) <b>Northeast, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>5/25/57</b>		24b. REGISTRAR'S SIGNATURE <b>Barton S. Belmont</b>	

MAY 27 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05570

## CERTIFICATE OF DEATH

05561

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SADIE</b> Middle <b>LILLISTON</b> Last <b>HUFFMAN</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Accomack County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Lilliston</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Mears</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John T. Evans--Peyton's Rd.--Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage &amp; Hemiplegia</b> <b>331X</b> DUE TO <b>left</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>left</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>54</b> , to <b>May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 20</b> , 19 <b>57</b> , and that death occurred at <b>6:30 A.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. G. Rawley</b>		DATE SIGNED <b>5/22/57</b>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 22, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 5/23/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Barbara S. Nelson</b>			

RECEIVED



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 5-29-57 et

CERTIFICATE OF DEATH

05563

05571

Reg. Dist. No.

265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>				c. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>McCreedy Hospital</u>				e. STREET ADDRESS <u>Washington St</u>			
3. NAME OF DECEASED (Type or print) <u>John W. May</u>				4. DATE OF DEATH <u>May 12 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18 1878</u>	
9. AGE (In years, months, days, hours, minutes) <u>79</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>John W. May</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Ann McHorman</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215-84-9493</u>				17. INFORMANT <u>Alfred May</u> Address <u>Princess Anne</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Condition - 2 days</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis - Nephritis</u> DUE TO (c) <u>Enlarged prostate -</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years -</u> <u>years -</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>610x</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>May 11, 1957</u> to <u>May 12, 1957</u> , that I last saw the deceased alive on <u>May 12, 1957</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry C. Coulbourn</u> M.D. <u>Marion Sta. Md</u>				DATE SIGNED <u>5-13-57</u>			
PHYSICIAN'S NAME (Type) <u>Henry C. Coulbourn - M.D.</u>				<u>Marion Sta. Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Andrews Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Harmon</u>				24. REC'D BY REGISTRAR <u>5-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>	

CERTIFICATE OF DEATH

1957

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is filled out with handwritten text.

BUREAU V. 4

MAY 16 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05564

05572

## CERTIFICATE OF DEATH

Reg. Dist. No.

160

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>				c. LENGTH OF STAY IN 1b <b>64 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lottie</b> Middle <b>E.</b> Last <b>McDorman</b>				4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1892</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Milligan</b>				14. MOTHER'S MAIDEN NAME <b>Ida Nelson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Mr William McDorman Westover, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Sclerosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary embolism</b> DUE TO <b>420.1</b> (c) <b>Varicose Veins + Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1-3 yrs.</b> <b>" "</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previously Hypertension + Nephritis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>442x</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 1958</b> to <b>May 23 1957</b> , that I last saw the deceased alive on <b>May 23 1957</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Princess Anne, Md.</b> DATE SIGNED <b>May 27, 1957</b>							
ACTUAL SIGNATURE <b>A.C. Lewis</b>		M.D. <b>May 27, 1957</b>					
PHYSICIAN'S NAME (Type) <b>A.C. Lewis, M.D.</b>		<b>Princess Anne, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-25-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leon Wilson</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dr. R. H. Johnson</b>		DATE	

# CERTIFICATE OF DEATH

REGISTERED

MARYLAND

ESTOVER

ESTOVER

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WHITE

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MARYLAND

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IDA NELSON

WILLIAM H. WILLIAMSON

WILLIAM H. WILLIAMSON

NO

NO

BUREAU V. S.

MAY 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05565

05566

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>320 Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>R.</b> Last <b>STEVENS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1863</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Roach</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Gunby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Henrietta Coulbourn-Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Wrenia Acute Del 7 Hurt</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Int. degenerative Chronic myocardi</b> DUE TO (c) <b>Senile Arterio Sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>592X 2mm</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>56</b> , to <b>May 21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 22</b> , 19 <b>57</b> , and that death occurred at <b>4:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Marion Station, Md.</b> DATE SIGNED <b>5/22/57</b> ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D. <b>Marion 2nd</b> PHYSICIAN'S NAME (Type) <b>Dr. George C. Coulbourn</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>5/23/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Bertan S. Adams</b>			



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise.

RECEIVED  
MAY 27 1957  
BUREAU V. S.

Continuation of the death certificate form, containing additional fields for medical history, autopsy results, and official signatures. The text is rotated 90 degrees clockwise.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

05573

## CERTIFICATE OF DEATH

05566

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Crisfield</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>		d. STREET ADDRESS <b>1 Lawsonia Section</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>NANCY</b> Middle <b>ELIZABETH</b> Last <b>TYLER</b>		4. DATE OF DEATH <b>May 22 19 57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1869</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>George Tyler</b>		14. MOTHER'S MAIDEN NAME <b>Jane Sterling</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Mrs. Alex Tyler--Lawsonia--Crisfield, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>241x Bronchial Asthma</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>1952</b> , to <b>May 22, 1957</b> , that I last saw the deceased alive on <b>May 22, 1957</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main St.--Crisfield, Md.</b> DATE SIGNED <b>May 23, 1957</b>				
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D. <b>334 Main Crisfield, Md.</b>				
PHYSICIAN'S NAME (Type) <b>Dr. Sarah M. Peyton</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 24, 1957</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		ADDRESS		
24a. REC'D BY REGISTRAR <b>DATE 5/23/57</b>		24b. REGISTRAR'S SIGNATURE <b>Bert S. Adams</b>		

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		SUICIDE		BUSINESSMAN		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY	
POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE	
DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT	
HOME		HOME		HOME		HOME		HOME		HOME		HOME		HOME	
DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY	
POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE	
DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT	
HOME		HOME		HOME		HOME		HOME		HOME		HOME		HOME	

BUREAU V. E.

MAY 27 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05567

CERTIFICATE OF DEATH

05567

Reg. Dist. No. 265

1. PLACE OF DEATH o. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> x0	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1st Street</u>		d. STREET ADDRESS <u>1st Street</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Lake Wharton Jr.</u>		4. DATE OF DEATH <u>May 23 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaford Tacker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Lake Wharton Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Julia W. Hix</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Lake Wharton Crisfield</u>	
17. INFORMANT <u>Lake Wharton Crisfield</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Was attended some time by Dr. R. B. Barr for Cardiac Disease</u> (c) <u>Natural Cause</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Cause</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	
21. I certify that I attended the deceased from _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Coulbourn</u> M.D.		DATE SIGNED <u>May 25 1957</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sunnyside</u>		22d. LOCATION (City, town, or county) <u>Dorchester</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Harmon</u> ADDRESS <u>Princess Anne</u>		24a. REC'D BY REGISTRAR <u>5/25/57</u> 24b. REGISTRAR'S SIGNATURE <u>Burtan S. Adams</u>	

William H. Coulbourn, M.D.  
DEPUTY MEDICAL EXAMINER  
FOR SOMERSET COUNTY, MD.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED  <i>John Doe</i></p>		<p>2. SEX  <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. AGE  <i>45</i></p>		<p>4. RACE  <i>White</i></p>	
<p>5. DATE OF DEATH  <i>May 20, 1957</i></p>		<p>6. TIME OF DEATH  <i>10:00 AM</i></p>	
<p>7. PLACE OF DEATH  <i>Home</i></p>		<p>8. CAUSE OF DEATH  <i>Heart Disease</i></p>	
<p>9. DISEASE OR INJURY  <i>Myocardial Infarction</i></p>		<p>10. MANNER OF DEATH  <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined</p>	
<p>11. SIGNATURE OF PHYSICIAN  <i>[Signature]</i></p>		<p>12. SIGNATURE OF DEATH REGISTRAR  <i>[Signature]</i></p>	
<p>13. SIGNATURE OF WITNESS  <i>[Signature]</i></p>		<p>14. SIGNATURE OF DEATH REGISTRAR  <i>[Signature]</i></p>	

BUREAU V. S.

MAY 27 1957

RECEIVED